



# ADVANCED DENTISTRY

General, Cosmetic & Sleep Solutions

Name \_\_\_\_\_ Email \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_  
Last Name First Name Initial City State Zip

Best Number to reach you # \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

### MEDICAL HISTORY

Have you ever had any of the following? (Circle all that apply)

- |                            |                         |                     |                          |             |
|----------------------------|-------------------------|---------------------|--------------------------|-------------|
| Heart Murmur               | Epilepsy                | Rheumatic Fever     | High/Low Blood Pressure  | Hepatitis   |
| Diabetes                   | Cancer/Chemotherapy     | Sinus Problems      | Asthma/Arthritis         | Ulcers      |
| Artificial Valves/Joints   | Congenital Heart Defect | Radiation Treatment | Blood Transfusion        | Anemia      |
| Difficulty Breathing       | Emphysema/Glaucoma      | Heart Attack/Stroke | Heart Surgery/ Pacemaker | Hemophilia  |
| HIV/AIDS                   | Kidney Problems         | Shingles            | Mitral Valve Prolapse    | Oral Herpes |
| Severe/ Frequent Headaches |                         |                     |                          |             |

Please explain any circled conditions from the above \_\_\_\_\_

Do you have any drug allergies or have you ever had an adverse reaction to any medication? \_\_\_\_\_

Current Medications \_\_\_\_\_

Chief complaint or concern for today's appointment \_\_\_\_\_

**For Emergency Visits only** (it is not necessary to fill out if this is only for a consultation)

What is your pain level on a scale of 1-10? \_\_\_\_\_

How long has the pain been going on? \_\_\_\_\_

I understand that the above information will help Dr. Popp & Dr. Bailey determine appropriate and healthy dental treatment. If there is any change in my medical status, I will inform her. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_